Normal Cognitive Aging and Dementia: What Counselors and MFTs Need to Know

June 20, 2024

Sponsored by the Medicare Mental Health Workforce Coalition

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1. **Closed Captioning** is enabled and attendees can turn CC on or off as they desire.

2. **Interpreter Phone Number:** 305-224-1968  
   **Webinar ID:** 843 6298 2022  
   **Passcode:** 491432

3. **Session Evaluation / Take Our Evaluation Survey**  
   (CE credit for live attendance only)

4. Webinar will be posted on NBCC website a few days following the webinar.

5. **Q&A:** Please add your questions in the Q&A box at any time during the meeting.
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<td>American Counseling Association</td>
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<td>Michael J. Fox Foundation for Parkinson’s Research</td>
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Suzanne Musil, PhD, ABPP-CN, is a board-certified clinical neuropsychologist in the Memory Care Program at MyMichigan Health in Midland, Michigan. Throughout her career, she has specialized in working with older adults, with expertise in the differential diagnosis of normal aging versus dementia and dementia-related conditions.

Dr. Musil is frequently asked to speak on this topic and enjoys educating patients, family members, and health care professionals on topics related to cognitive aging.
E4 Center of Excellence for Behavioral Health Disparities in Aging

Engage, Empower, and Educate health care providers and community-based organizations for Equity in behavioral health for older adults and their families across the US.

To learn more, please visit e4center.org
E4 Center: Engage, Educate & Empower for Equity
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Upcoming E4 Center Events

Aging and Traumatic Brain Injury: Understanding the Intersection and Implications
Teresa Ashman, PhD, ABPP-RP
Wednesday, July 10
10-11:30 PT/11-12:30 MT/12pm-1:30 CT/1-2:30 ET

Caregiving in Aging Families
Sara Qualls, PhD, ABPP
First Three Fridays of September
8-11AM PT/9AM-11AM MT/10AM-12PM CT/11AM-1PM ET

REGISTER HERE: https://e4center.org/calendar/
Foundational Competencies in Older Adult Mental Health Online Certificate Program

The growing population of older adults presents a unique opportunity for mental health professionals to expand clinical practice and experience deeply meaningful clinical work.

This peer-reviewed, 16-hour online certificate program provides foundational knowledge in older adult mental health for health care providers who work with older adults.

HOT OFF THE PRESSES!

Anti-Elderspeak Language Guide

We are ALL aging – how would you want to be spoken to?

Through verbal and non-verbal language, we can celebrate adult personhood by acknowledging and honoring older adults’ unique identities, yet our speech can get in the way. Elderspeak uses over-simplified language and is often driven by ageist stereotypes or the belief that accommodation is needed. While aimed at expressing care or enhancing comprehension, it is demeaning, and can make caregivers seem less respectful or nurturing, dominant, and unfriendly.

<table>
<thead>
<tr>
<th>Try saying this:</th>
<th>Instead of saying this:</th>
<th>Because:</th>
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<tbody>
<tr>
<td>Older Adult/Person/People</td>
<td>Senior/Senior Citizen Elderly</td>
<td>Implies frailty, dependence, and perpetuate stereotypes</td>
</tr>
<tr>
<td>Person with dementia or cognitive impairment</td>
<td>Demented Senile</td>
<td>Disrespectful and contributes to stigma</td>
</tr>
<tr>
<td>&quot;You are beautiful!&quot;</td>
<td>&quot;You are beautiful for your age!&quot;</td>
<td>Implies that youth is superior, and aging is shameful or undesirable</td>
</tr>
<tr>
<td>&quot;You have a vibrant energy!&quot;</td>
<td>&quot;You are young at heart!&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot;How can I help you be safe?&quot;</td>
<td>&quot;Should you still be doing that?&quot;</td>
<td>Can discourage activity and implies that getting older guarantees dependence or inability to perform tasks</td>
</tr>
<tr>
<td>&quot;I admire your independence. Do you need any support?&quot;</td>
<td>&quot;You live alone at your age? You're so independent!&quot;</td>
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Normal Cognitive Aging and Dementia: What Counselors and MFTs Need to Know

Suzanne Musil, PhD, ABBP-CN
06-20-2024

Grant#: 6H79FG000600-01M001
SAMHSA’s mission is to reduce the impact of substance misuse and mental illness on America’s communities.
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
I have no relevant financial relationships to disclose.
By the end of this presentation, learners should be able to:

- describe normal age-related change in cognitive abilities
- differentiate between normal age, mild cognitive impairment, and dementia
- recognize the distinct memory impairment seen in Alzheimer’s disease
- use appropriate communication for persons with and without dementia
- assist older patients with lifestyle adaptations to reduce risk of future cognitive decline
Outline

Part 1: Normal
• brief overview of brain anatomy and function
• cognition and normal aging

Part 2: Abnormal
• normal cognitive aging versus mild cognitive impairment versus dementia
  ---- BREAK ----
• treatable causes of cognitive impairment

Part 3: Working with older adults
• communication strategies for older adults with and without cognitive impairment
• prevention
Janet: First encounter

76-years-old

background
retired school teacher
married for 53 years, recently widowed
3 children, 5 grandchildren

presenting problem
husband died from cancer and she was his caregiver
you are seeing her for adjustment to widowhood

medical history
hypertension
borderline diabetes
mildly high cholesterol
arthritis
hypothyroid

Medications
lisinopril
levothyroxine
ibuprofen
Janet: 1st encounter

**cognition**
- feels like her memory has been “not so good” over the last couple of years
- forgets why she got up to do something
- misplaces her glasses
- trouble coming up with words she wants to use

**function**
- described herself as fully independent
- makes appointments with you on her own; never misses
- fairly good carryover between sessions, but sometimes you need to remind her
What matters

• to be self-sufficient
• to stay as independent as possible
• play an active role with her grandchildren

Janet: 1st encounter
Normal?
Abnormal?
Normal aging

- Brain function
- Cognition
Executive functions

Personality/behavior

Memory

Visuospatial abilities

Language
white matter – connect brain areas
information “highways”

frontal lobes

cortex – where conscious thought processes take place
How does the brain age “normally”? 

• “normal” can be hard to define
• we see same changes in normal aging and disease
• there is loss of brain volume
  – atrophy
• white matter changes
  – loss of connections
  – vascular changes
• reduced blood flow
• most changes are seen in the frontal lobes
Frontal lobe functions

• “executive functions”
  – high level thinking abilities that allow us to execute appropriate behavior for the situation
    • monitor behavior and environment
    • planning, problem solving, mental flexibility, organization, reasoning, judgment, etc.

• also assist with memory
Memory works in stages

Encoding
what you can consciously hold on to and work with

Storage
for memory later, must be stored permanently

Retrieval
to remember later, have to take it out of storage
Encoding  
Retrieval  
Storage  
frontal lobe / white matter  
normal aging and other dementias  
temporal lobe  
Alzheimer’s disease
“present moment” depend on attention
Two types of memory impairment

- Information is harder to get in and get back out
- Normal aging

- New memories do not get made
- Never normal
Other normal, age-related cognitive changes

**Attention**
- *basic attentional abilities remain intact*
- *speed of processing declines*

**Executive Function**
- *declines in many aspects*
- *other aspects preserved*

**Language**
- *some word-retrieval problems*
- *otherwise, preserved*
- *vocabulary grows with age*

**Visuospatial Abilities**
- *generally stable*
Not Normal Aging

- problems sustaining attention
- certain kinds of memory problems
- difficulty understanding or expressing language
- visuospatial problems
- significant changes in personality and behavior, problems with:
  - social behavior
  - judgment
  - awareness
Normal or abnormal?
• work with Janet for 4 months
• she makes good progress
• terminate treatment
From Normal to Dementia
From normal aging to dementia

- Normal age-related change
- Mild Cognitive Impairment (MCI)
- Interference with daily activities = Dementia

Graph showing the progression from good to poor cognitive function over time.
Dementia: Umbrella term for multiple diseases

2 criteria

• “Significant” decline in cognition or behavior
• Interferes with a person’s ability to carry out daily activities
Dementia diagnosis is confusing

dementia and MCI are different names for different stages of \textit{same} disease

- MCI originally conceptualized to reflect the pre-dementia stage of Alzheimer’s disease
- any dementing process will have a corresponding MCI
  - the stage between normal aging and functional impairment
- MCI is a risk factor for dementia
Dementia diagnosis is confusing

• diagnosis can represent:
  – the disease
    • e.g., Alzheimer’s disease
  – where in the brain the disease starts
    • frontotemporal degeneration
  – the clinical presentation of the disease
    • primary progressive aphasia

All 3 of these labels may be correct!

early clinical presentation correlates with neuroanatomy, NOT pathology

• focal vs diffuse
Two types of memory problems

Storage

• inability to make/store new memories
  – poor memory for recent events
  – memories made prior to the disease are preserved
• little to no insight

Encoding and retrieval

• memories do get made; inefficient, inconsistent
• hints and cues can help
• patients usually aware of the problem
Alzheimer’s disease – Early presentation

• most common: 60-80% of cases
• cause: abnormal proteins accumulate, cause cell death (atrophy)
  – plaques and tangles
• temporal lobe memory centers (focal)
  – storage problem
• cognition:
  – poor memory for recent events
  – naming/word-finding
  – lack of insight
Vascular disease –
Early presentation

• 2\textsuperscript{nd} most common cause of cognitive decline

• cause: microvascular ischemic disease (diffuse) or stroke (focal)

• associated with high blood pressure, diabetes, high cholesterol, etc.

• other risk factors: smoking, obesity, age

• cognition:
  – memory encoding/retrieval
  – slow processing speed
  – executive dysfunction
Alzheimer’s disease \( \cap \) vascular disease = 75% of dementia cases
Update on Janet

- Janet contacts you to resume treatment
- grandson was killed in an accident 2 months ago – highly depressed
- neglected her health for several months
  - blood pressure uncontrolled
  - diabetes
  - high cholesterol
- daughter stepped in to help out

2nd encounter:
6 months after terminating 1st treatment
cognition

- Janet feels like she is “losing it”
- afraid she has Alzheimer’s disease
- much more forgetful, repeats herself, frequently misplaces things

function

- daughter oversees medications and appointments, brings her to sessions
- more forgetful about session content

2nd encounter:
6 months after terminating 1st treatment
What’s going on now?

- Normal?
- MCI?
- Dementia?
Why not dementia?

- don’t diagnose a chronic condition in the presence of acute factors

some causes of cognitive impairment are treatable – Janet meets criteria for major depressive disorder
Treatable causes of cognitive impairment
Depression and memory

• most psychiatric diagnoses have a criterion of cognitive impairment
  – problems with attention and concentration

• attention-based memory problems

• things that take away from attention in-the-moment, will cause encoding and retrieval memory problems
Treatable Causes of Cognitive Impairment

• mood disturbance
  – age-appropriate mood screening

• nutritional deficiency
  – medical evaluation

• obstructive sleep apnea
  – referral for sleep study

• delirium
  – acute confusional state due to a medical condition
Delirium: A variety of disturbances

- Consciousness
- Orientation
- Perception
- Sleep–wake cycle
- Thought processes
- Behavior

Cognition
Cognitive Presentation

• profound attentional disorder, affects all other thinking skills
• memory is impaired because they can’t process information very well or quickly
  • encoding problem
Delirium risks/causes

Predisposing factors:
- older age
- baseline cognitive impairment
- functional disability
- sensory loss
- multiple co-existing medical problems

Triggering factors:
- medications
- surgery
- anesthesia
- pain
- infection
- acute illness
Delirium in older adults

• more frequent and more serious
• occurs with less provocation
  – could be multiple subclinical problems
• onset and recovery are slower
  – especially with pre-existing cognitive impairment
• misdiagnosis is common
  – as depression
  – as dementia
Delirium awareness

• for abrupt changes in cognition, consider medical etiology *before* dementia diagnosis
• ask about all medications, especially new ones
  – prescription AND over-the-counter
  – vitamins
  – supplements
• does the person get all medicines from the same pharmacy?
• check American Geriatrics Society Beers Criteria®
  – potentially inappropriate medication use in older adults
• are all medical providers in communication with each other?
• discuss with primary care doctor
Janet: next steps

- strong temporal correlation between onset of depression and onset of memory problems
- could be medical etiology
  - worsened vascular health
- ask about sleep
  - no sleep apnea
- ask about all medications and supplements, are any new?
  - she’s been taking Benadryl to fall asleep, advise her to stop
- consider cognitive evaluation

2nd encounter:
6 months after terminating 1st treatment
Assessing Cognition

- screeners are helpful for staging, not determining dementia type
- memory assessment is not adequate:
  - can’t determine type of memory problem
- formal neuropsychological evaluation is best:
  - assess cognition in the context of premorbid ability, motivational factors, etc.
  - very sensitive to very early cognitive changes from neurodegenerative disease
Assessing memory storage informally in the office

**temporal orientation**
- date: month, year, and exact date
- day of the week
- time of day

**current events**
- Do you keep up with news?
- What’s going on the news these days?
- It’s OK to give a hint to get them started.
poor orientation

poor current events

storage problem

probably Alzheimer’s disease
2nd encounter: 3 months after resuming treatment

depression is greatly reduced

cognition
  - memory is better, but not back to where it was when you first saw her
  - same type of memory problem – encoding and retrieval

function
  - benefits from memory support
    - provide written information to supplement sessions
    - repeat main points
  - independent again
Janet may have MCI – you suspect a vascular cause, not Alzheimer’s disease

• refer her for neuropsychological evaluation
Working with older adults

- Communication
- Prevention
What’s wrong with this communication?
# Tips for effective communication with cognitively normal older adults

- **#1:** don’t assume!
- **do** make adjustments for normal cognitive aging

<table>
<thead>
<tr>
<th>the cognitive change</th>
<th>the solution</th>
<th>there is no need to:</th>
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</table>
| • slower processing speed | • don’t speak too fast  
• allow a little more time for processing | • use simple words  
• speak slowly  
• shout  
• use “baby talk” |
communication that treats a person like a child or a pet

- high-pitched voice
- using overly endearing terms
- using the collective “we”
Other adjustments to communication

<table>
<thead>
<tr>
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<th>the solution</th>
<th>there is no need to:</th>
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</thead>
</table>
| *hearing loss*  
  more common in men  
  affects higher-frequency pitch | *“low and slow”*  
  pitch voice lower  
  slow down rate  
  remove background noise  
  try written communication | *scream, shout*  
  automatically direct speech to others |
Communication with cognitively impaired older adults

Don’t you remember??
Set the stage

• approach the person from the front, at their eye level
• sit down if possible
• make eye contact
• remedy any sensory deficits
  – eyeglasses
  – hearing aids
  – lighting
What you say

• introduce yourself and your role
• use the person’s preferred name
• explain what you are doing and why
• ask one thing at a time
• give choices whenever possible
• don’t argue, correct, or try to convince
• do provide comfort and reassurance
How you say it

• don’t use elderspeak
• be attentive to the person’s behavior
• be patient, and allow time for a response
• be aware of your own feelings and how they may impact care
• be aware of your own nonverbal behavior
  – e.g., tone of voice, facial expression, etc.
  – show you are listening
Adjusting for memory problems

- storage problems
  - i.e., Alzheimer’s disease
  - memory for recent events will be poor
  - hints and cues are *not* helpful
    - and can increase distress, frustration, suspiciousness
  - repeating stories or questions is common
    - the person *does not remember* asking before
    - there is no need to remind them, just answer the question again
Adjusting for memory problems

• encoding/retrieval problems
  – important recent information will sink in
  – hints and cues are helpful
    • giving a little extra context can help bring out a memory
  – repetitiveness can be common, but
    • information given again will be familiar
How do we have conversations with older persons about cognition?
Why patients might not discuss memory loss with their providers

- stigma about memory loss
- fear of the consequences of the diagnosis
- why get a diagnosis if there is no cure
- bringing it up may just bring more referrals or prescriptions they don’t want
- may be unconcerned, think it’s normal
Why *providers* might not discuss memory loss with their patients

- may defer to patients or family members to bring it up
- may be awkward or uncomfortable
- it’s a difficult conversation
- lack of specialists to refer patients to
- health care providers want to treat – there is little to offer patients
Overcoming barriers

**have conversations early**

- ask what matters
- encourage open family communication
- talk about advance directives: they’re about life
- be open about limitations of treatment, but
- let patients know what a health care plan for memory might look like
- focus on prevention – positive approach
41% of dementia cases can be attributed to 12 modifiable lifestyle factors:

- Obesity
- Inactivity
- Hypertension
- Diabetes

Percentage is higher in Black and Hispanic Americans.

It’s never too late to derive some benefit from a lifestyle change.
Dementia Prevention

- manage cardiovascular health
- regular physical exercise
- heart-healthy diet
  - Mediterranean-type diet: MIND diet
- smoking cessation
- healthy sleep habits
- use hearing aids
- cognitive and social engagement
Janet:

- had neuropsychological evaluation: diagnosed with MCI - vascular
- assist with lifestyle modification to improve vascular and brain health and reduce her risk of progressing to dementia
  - education
  - motivation
  - overcoming barriers to adherence

2nd encounter:
last few weeks of treatment
Wrapping up – Take home points

- with age, there is slowing of processing speed and memory encoding and retrieval problems

- MCI and dementia are umbrella terms based on degree of cognitive impairment and level of independence

- Alzheimer’s disease causes a storage problem: difficulty retaining information over time

- make adjustments in communication appropriate for the person

- have conversations about cognition early and adopt a positive approach focused on prevention
For Janet...

- helped her avoid misdiagnosis
- saved her from unnecessary tests and procedures
- reduced her need for medications
- helped her retain her independence
- gave her tools to help reduce her risk for dementia in the future
Questions and Answers
Resources
Critical Resources on Medicare Part B Coverage of Counselors and MFTs

Legislation Mandating Medicare Part B Coverage of Counselors and Marriage and Family Therapists
https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

How to Enroll in the Medicare Program

- Medicare Enrollment for Providers and Suppliers
  https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos

- New Provider Type: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
  FAQs (36 questions answered) Published Sept 2023

- The Medicare Learning Network:

- Web-based Training:

- Becoming a Medicare Provider (World of Medicare):

- Weekly Email Newsletter for Medicare Providers:
Role of the Centers for Medicare and Medicaid Services (CMS)


Medicare Mental Health Benefits for Beneficiaries

Medicare and Your Mental Health Benefits:  

Medicare Mental Health:  

Medicare Beneficiary Handbook:  
Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Medicare Administrative Contractors (MACs)
https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac

Medicare Physician Fee Schedule

Key Steps to Becoming a Medicare Provider

1. Register in the I&A System
2. Get an NPI
3. Enter information into PECOS
4. Decide if you want to be a participating provider

Form CMS-855I: Physicians and non-physician practitioners (PDF link)
Thank you for attending!